

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-016680

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 179

Primary Registration District No. 5673

Registrar's No. 75

STATE FILE NUMBER

FILED MAY 13 1963

VS 300
Rev. 4/59

1 0570

2 0570

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Lincoln		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lincoln	
b. CITY (If outside corporate limits, give TOWNSHIP only) Monroe Township		Length of stay in 1b 20 years	c. CITY OR TOWN Winfield Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RED-1/2 mile East of Winfield		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1/2 mile east of Winfield Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) SARAH CATHERINE SMITH		4. DATE OF DEATH Month May Day 5 Year 1963	
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-18-88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	9. AGE (last birthday) 74 IF UNDER 1 YEAR Months Days Hours Min.
13a. FATHER'S NAME George Presley		13b. MOTHER'S MAIDEN NAME Martha Reeves	14. NAME OF HUSBAND OR WIFE Sherman Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. [redacted]	17. INFORMANT Address husband Sherman Smith - Winfield, Mo.
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Failure DUE TO (b) Cerebral Hemorrhage DUE TO (c) [redacted] Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Incontinence and Debilitation			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour [redacted] a.m. [redacted] p.m. [redacted]	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from July 1960 to Present and last saw her alive on January, 1963 Death occurred at 7:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature] (Degree or title)		22b. ADDRESS Winfield, Mo.	22c. DATE SIGNED 5-6-63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 5-7-63	23c. NAME OF CEMETERY OR CREMATORY Wilson Cemetery	23d. LOCATION (City, town, or county) (State) Batchtown, Ill.
24. FUNERAL DIRECTOR Ricks Funeral Home		25. DATE RECD. BY LOCAL REG. 5-7-1963	26. REGISTRAR'S SIGNATURE Charlotte Leake

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Charles K. ...

Licensed Embalmer No. 4012

P. O. Address Elmhurst, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.